TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Conroe Regional Medical Center

Respondent Name
TASB Risk Mgmt Fund

MFDR Tracking Number
M4-16-2190-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
March 28, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is our belief that we have submitted satisfactory proof that this claim was billed to the health care carrier within 95 days from March 3, 2015 and that it was submitted to the Worker's Compensation Carrier within 95 days from the date that it was learned that it should be billed to Workers' Compensation and should be adjusted for payment."

Amount in Dispute: $75,120.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "These original bill was submitted on 11/11/2015. It was timely processed within the 45 day timeframe on 12/02/2015 and denied appropriately due to being submitted past the timely filing requirements as per Rule 133.20. The provider did not submit any proof of timely filing or letter of explanation with the bill."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 30, 2015 through April 3, 2015	Inpatient Hospital Services	$75,120.00	$14,629.31

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.

5. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical claim.
6. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. What is the applicable rule for determining reimbursement of the disputed services?
3. What is the recommended payment for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied the disputed services with claim adjustment reason codes: 29 – "The time limit for filing has expired." 28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." Texas Labor Code §408.0272(b) provides that:

   > Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:
   > (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:
   > (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;
   > (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or
   > (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or
   > (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

   Review of the submitted documentation finds the following:

   - Electronic Remittance from Aetna showing submission and acceptance of claim on May 15, 2015
   - Electronic note from requestor showing on October 29, 2015 notification made of Worker's compensation insurance and the claim should be submitted to TASB
   - Creation date of 11/5/2015 on medical claim form submitted to TASB

   Review of the submitted information found sufficient documentation to support that a medical bill was submitted within 95 days from the date of the notification of worker's compensation coverage. Consequently, the requestor has not forfeited the right to reimbursement due to untimely submission of the medical bill, pursuant to Texas Labor Code §408.027(a). The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. This dispute regards the facility medical services of an inpatient acute care hospital with reimbursement subject to the provisions of Code 28 Texas Administrative Code §134.404(f), which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule.

   Per §134.404(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 143 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that

separate reimbursement for implantables was not requested; for that reason, the MAR is calculated according to §134.404(f)(1)(A).

3. Per §134.404(f)(1)(A), the sum of the Medicare facility specific amount, including any outlier payment, is multiplied by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 494. The services were provided at Conroe Regional Medical Center. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $10,230.29. This amount multiplied by 143% results in a MAR of $14,629.31.
4. The total recommended payment for the services in dispute is $14,629.31. The insurance carrier has paid $0.00. The amount due to the requestor is $14,629.31. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $14,629.31.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $14,629.31, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		April , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.